# 2009 H1N1 Influenza Vaccine Consent Form (Schools)

**PANHANDLE HEALTH DISTRICT**
8500 N. Atlas Road, Hayden, ID 83835 208-415-5180

**Section 1: Information about Child to Receive Vaccine (please print)**

| | | | | |
|---|---|---|---|---|
| **STUDENT'S NAME** (Last) | (First) | (M.I.) | **STUDENT'S DATE OF BIRTH** month_____ day_____ year _____ | |
| **PARENT/LEGAL GUARDIAN'S NAME** (Last) | (First) | (M.I.) | **STUDENT'S AGE** | **STUDENT'S GENDER** M / F |
| **ADDRESS** | | | **PARENT/GUARDIAN DAYTIME PHONE NUMBER:** | |
| **CITY** | **STATE** | **ZIP** | | |
| **SCHOOL NAME** | **GRADE** | | **TEACHER/HOMEROOM** | |

**Section 2: Screening for Vaccine Eligibility** (Children age 9 and under will require two doses of vaccine.)

**If your child has already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the number of doses and dates of vaccination.**

☐ Dose 1 Date received: month ____day____year_____ Type (please circle): nasal spray shot

☐ Dose 2 Date received: month ____day____year_____ Type (please circle): nasal spray shot

**The following questions will help us to know if your child can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.**

**A. If you answer "NO" to all 4 of the following questions, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following 4 questions, your child will not get the 2009 H1N1 vaccine at their school, but please contact your child's doctor to discuss your options.**

| | YES | NO |
|---|---|---|
| 1. Does your child have a severe allergy to eggs? | ☐ | ☐ |
| 2. Is your child allergic to any of the following: gelatin, Gentamicin, Polymyxin, Neomycin? | ☐ | ☐ |
| 3. Has your child ever had a serious reaction to a previous dose of flu vaccine? | ☐ | ☐ |
| 4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine? | ☐ | ☐ |

**B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine your child can get.**

| | YES | NO |
|---|---|---|
| 1. Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month_____day_____year_____ | ☐ | ☐ |
| 2. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? | ☐ | ☐ |
| 3. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)? | ☐ | ☐ |
| 4. Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)? | ☐ | ☐ |
| 5. Is your child pregnant? | ☐ | ☐ |
| 6. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)? | ☐ | ☐ |

**Section 3: Consent**

**CONSENT FOR CHILD'S VACCINATION:**

I have read or had explained to me the attached 2009-2010 Vaccine Information Statements (What you need to know sheets) for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

I GIVE CONSENT to Panhandle Health District and its staff for my child named at the top of this form to be vaccinated with the vaccine I checked below:

☐ Nasal OR Shot ☐ Nasal ONLY ☐ Shot ONLY ☐ ONLY with me present

This consent includes both dose 1 and dose 2 **IF** needed.

(If this consent form is not signed below, dated, and returned, your child will not be vaccinated at school.)

Signature of Parent/Legal Guardian _____ Date: month_____day_____year_____

**Section 4: Permission to Release Information**

I give permission to **enroll** my child and to **transfer** my child's immunization records into the **Idaho Immunization Reminder Information System (IRIS)** to ensure that this vaccination record is available to me, my child's healthcare providers, childcare providers, and schools. I understand I may be asked for information that will help ensure my child's records are accurate and will not be confused with another person's records, such as: mother's maiden name, gender, and child's eligibility for free vaccine. I authorize inclusion of all information into IRIS and redisclosure of this information from IRIS to authorized users. (Your child can still receive the vaccination if you do not authorize this release for IRIS.)

Date: month_____day_____year_____ _____ Signature of Parent/Legal Guardian / (Relationship to child)

**Section 5: Vaccination Record**

**FOR ADMINISTRATIVE USE ONLY**

| Vaccine | Date Dose Administered | Route | Dose (1st or 2nd) | Vaccine Manufacturer | Lot Number | Name and Title of Vaccine Administrator |
|---|---|---|---|---|---|---|
| 2009 H1N1 | | ☐ IM ☐ Intranasal | | Sanofi GSK Novartis MedImmune CSL | | |
| 2009 H1N1 | | ☐ IM ☐ Intranasal | | Sanofi GSK Novartis MedImmune CSL | | |

Date Updated: 10/02/2009